The Collaborative Assessment and Management of Suicidality (CAMS)

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Evidence-Based Treatments for Suicidality



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

National Institutes of Health National Institute of Mental Health 6001 Executive Boulevard Rm 8235 Bethesda, Maryland 20892

Opportunities to Improve Interventions to Reduce Suicidality: Civilian "Best Practices" for Army Consideration

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- With n=50 studies (in the world literature), there are remarkably few evidence-based treatments and interventions for suicidal risk
- We mostly know what does <u>not</u> work (e.g., medication only)
- What does work:
 - Dialectic Behavior Therapy (DBT)
 - Cognitive Therapy
 - Brief interventions with non-demand follow-up

^{*}This document was developed in support of the US Army's ongoing efforts to reduce suicides and suicidality among Army Soldiers, and submitted to General Peter Chiarelli, Vice Chief of Staff of the Army, in December 2009. An earlier version of this document was submitted to Mr. Robert Andrews, Special Assistant to the Secretary of the Army, and General Chiarelli, in May 2009. The current version has been updated and somewhat expanded, in particular by adding a section on quality assurance and performance metrics (Section III).

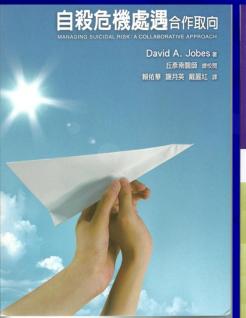
The Collaborative Assessment and Management of Suicidality (CAMS)

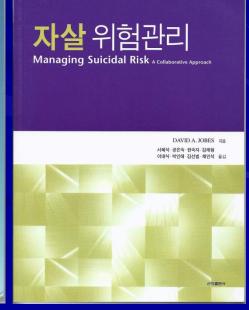
MANAGING Suicidal Risk

A Collaborative Approach

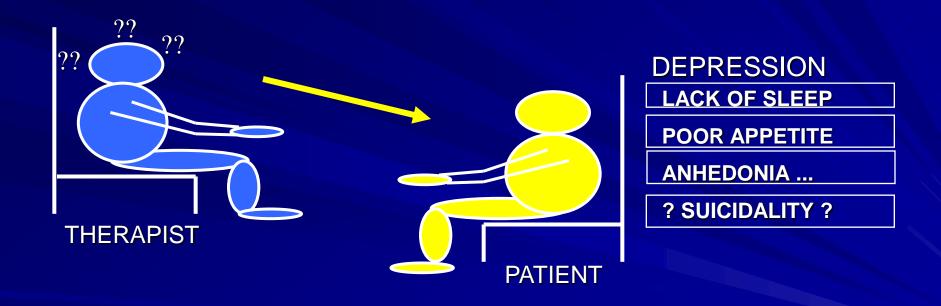
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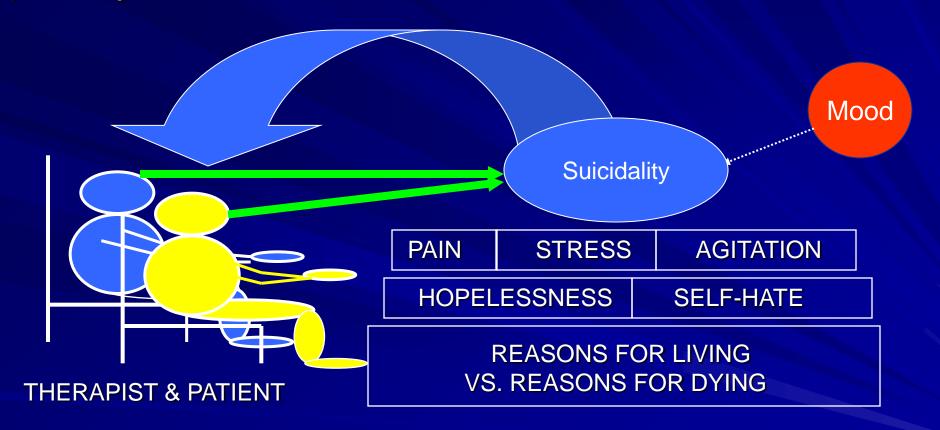


Critique of Current Approach to Suicide Risk: THE REDUCTIONISTIC MODEL (Suicide = Symptom of Psychopathology)



Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts...

The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets <u>Suicide</u> as the primary focus of assessment and intervention...



CAMS assessment uses the Suicide Status Form (SSF) as a means of deconstructing the "functional" utility of suicidality; CAMS as an intervention emphasizes a problem-focused intensive outpatient approach that is suicide-specific and "co-authored" with the patient...

Suicide Status Form-SSF II-R (Initial Section)

| | n A (Patient): | | | | | | | | | | |
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| Form-II-R (Initial Section—rec | |
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| | Suicid | e Status Form- | II-R (Init | al Session—page 2) | |
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| Single | Attempt Des | ribe: | | | |
| Multip | ele Attempts Des | ape | | | |
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Date Clinician Signature
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Patient Signature

Suicide Tracking Form

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| 2) RATE AGETATION (amotio | nel processor find the that you to | and to take action; wer | TRACK ME AND | enor's |
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| 4) RATE HOPELESSNESS (w | or espectation that things will | ergerlette so suite | wket you do): | |
| | Low hopelessness | 12345 | High hopelessness | |
| 5) RATE SELF-HATE (your gr | meral finding of distilling your | off having no self-exte | un; karang no self-re | spects: |
| | Lowedflut | K 12345 | High self-hate | |
| 6) RATE OVERALL RESK OF SLICCOR: | Extremely law rid (will <u>not</u> kill self) | E 12345 | Extremely high r (will kill set) | lek |
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| Section C (Clinician Outcome Evaluation): | | | | | | |
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| PATIENT'S OVERALL SUIC | CIDE RISK LEVEL (check one and explain): | | | | | |
| ☐ Mild ☐ Moderate | Explanation: | | | | | |
| ☐ Severe | | | | | | |
| CASE NOTES (diagnosis, functional risks, treatment plan, symptoms, prognosis, and progress to date): | | | | | | |
| | | _ | | | | |
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| Next Appointment Scheduled: | Treatment Modelity: | | | | | |
| Clinician Signature | Date Supervisor Signature Da | de | | | | |

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Psychometrics of the Core SSF (Jobes et al., 1997; Conrad et al., 2009)

TABLE 3
Convergent Validity: Correlations Between
SSF-II Items and Established Measures
of Similar Constructs

| SSF-II Item | Measure | n | Spearman rho |
|--------------|--------------|-----|-----------------|
| Pain | BHQ-20 | 113 | 35* |
| | OQ-45.2 | 127 | .45* |
| | OMMP | 110 | .43* |
| Stress | PI-III | 129 | .12 |
| | STICSA-S | 130 | .36* |
| | STICSA-T | 136 | .27* |
| | STICSA-Total | 121 | .31* |
| Agitation | STICSA-S | 128 | .42* |
| | STICSA-T | 134 | .28* |
| | STICSA-Total | 119 | .36* |
| | BIS | 133 | .36* |
| Hopelessness | BHS | 140 | .52* |
| Self-hate | BST | 141 | 37* |
| Overall Risk | L-RFL | 137 | 51* |

Note. *Correlation is significant at p < .01 (one-tailed).

TABLE 2
Factor Analysis Results: Spearman Promax
Rotated Factor Pattern

| SSF-II Item | Factor 1 | Factor 2 |
|--------------|----------|----------|
| Self-hate | .88*** | 09 |
| Hopelessness | .85*** | .05 |
| Pain | .74*** | .10 |
| Agitation | 07 | .92*** |
| Stress | .12 | .78*** |

Note. ***Value is greater than 0.4

TABLE 5
Comparison of Suicidal Patients to Nonsuicidal Patients
on SSF-II Items

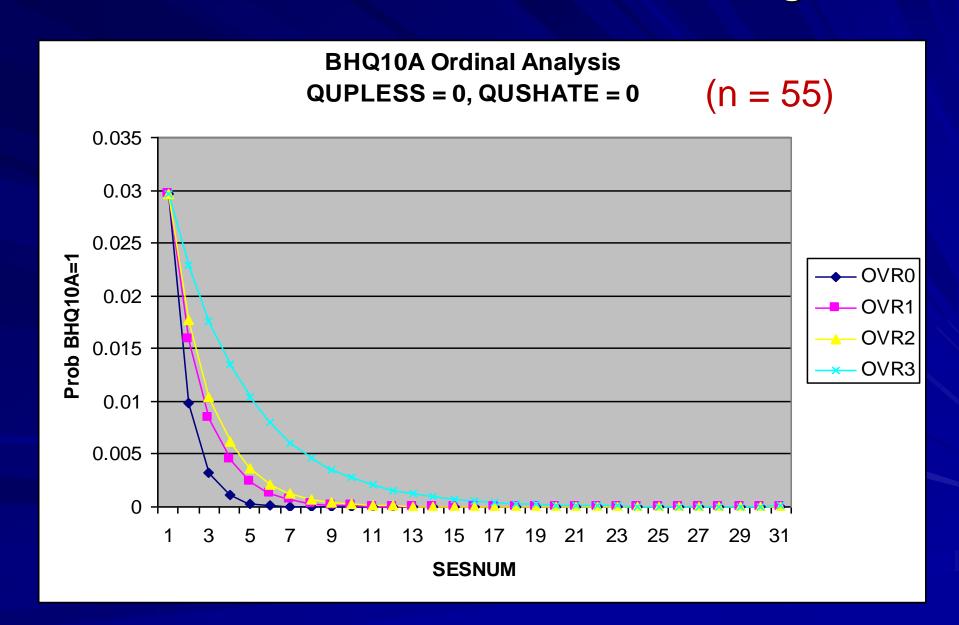
| | Suicidal patients | | Nonsu patie | Univariate | |
|--------------|----------------------|-------|----------------|------------|----------|
| SSF item | M | SD | M | SD | F |
| Pain | 3.82 | 1.24 | 3.44 | 1.34 | 2.644 |
| Stress | 3.87 | 1.25 | 3.78 | 1.35 | 0.133 |
| Agitation | 2.90 | 1.24 | 2.93 | 1.39 | 0.018 |
| Hopelessness | 3.81 | 1.29 | 2.83 | 1.41 | 16.030** |
| Self-hate | 3.74 | 1.31 | 2.88 | 1.44 | 12.083** |
| Overall risk | 2.68 | 1.27 | 1.55 | 0.77 | 28.467** |
| OQ-45 total | 125.22 | 23.13 | 130.47 | 26.10 | 1.63 |

Note. **F statistic is significant at p < .001.

Reliability

The first three test-retest t-test analyses yielded correlations that were statistically significant (Pain = .33, Stress = .23, Agitation = .35); however, the findings were more robust for the latter three variables (Hopelessness = .46; Self-Hate = .57, Overall Risk = .51). All correlations were significant at the p < .001 level, except the SSF *stress* correlation, which was significant at p < .05.

Index SSF Overall Risk rating differentially predicted four different reductions in suicidal thoughts...



RFL/RFD Cross Sectional Results (n=108) (Jobes, Stone, & Wagner, 2010)

| Measures | RFL | AMB | RFD | Test |
|------------------------------|--------|------------|--------|----------------|
| Beck Hopelessness Scale | 10.17 | 12.62 | 15.01 | F = 5.23** |
| Reasons for Living Inventory | 179.00 | 141.88 | 148.53 | F = 5.14** |
| WTL/WTD Suicide Index Score | 3,49 | 1.83 | -2.03 | F = 18.24*** |
| | | | | |
| Suicide Attempts | RFL | <u>AMB</u> | RFD | Test |
| 0-1 Attempts | 15 | 10 | 6 | |
| 2 or more Attempts | 5 | 11 | 15 | Chi-Sq = 7.83* |

^{*} p < .05, ** p < .01, *** p < .001

Adherence to CAMS as an Intervention: (Jobes, Comtois, Brenner, & Gutierrez, 2011)

CAMS is a <u>therapeutic framework</u>, used until suicidality resolves. Adherence to CAMS requires thorough suicide assessment and problem-focused interventions that are designed to target and treat direct and indirect "<u>drivers</u>" of suicide risk.

CAMS as a Therapeutic Philosophy

- **1.** Collaboration
 - Empathy with the suicidal wish
 - Clarify the CAMS agenda
 - All assessments/interventions are interactive
- 2. Suicide-focus ultimately guides all therapeutic activity

CAMS as a Clinical Framework

- 1. Assess index and on-going suicide risk using the SSF
- 2. All SSF-guided interventions are meant to eliminate direct or indirect causes of suicidal risk
 - A suicide-specific treatment plan with Crisis Response/Safety Plan
 - Reduce access to lethal means
 - Insure treatment attendance
 - Make referrals to address indirect causes of suicide

Overview to CAMS Assessment and Care

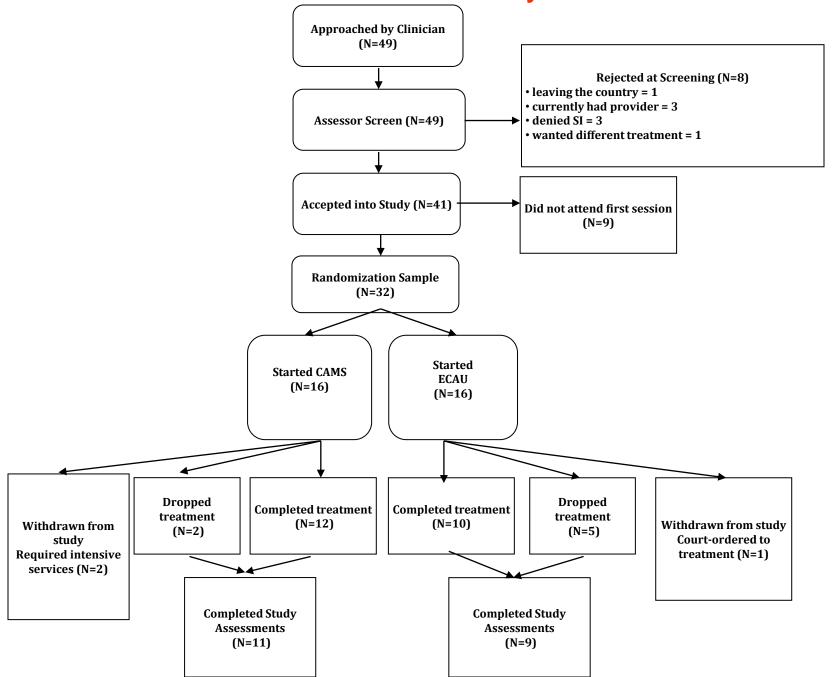
CAMS is a suicide-specific therapeutic framework, emphasizing five core components of collaborative clinical care (over 10-12 sessions/3 months).

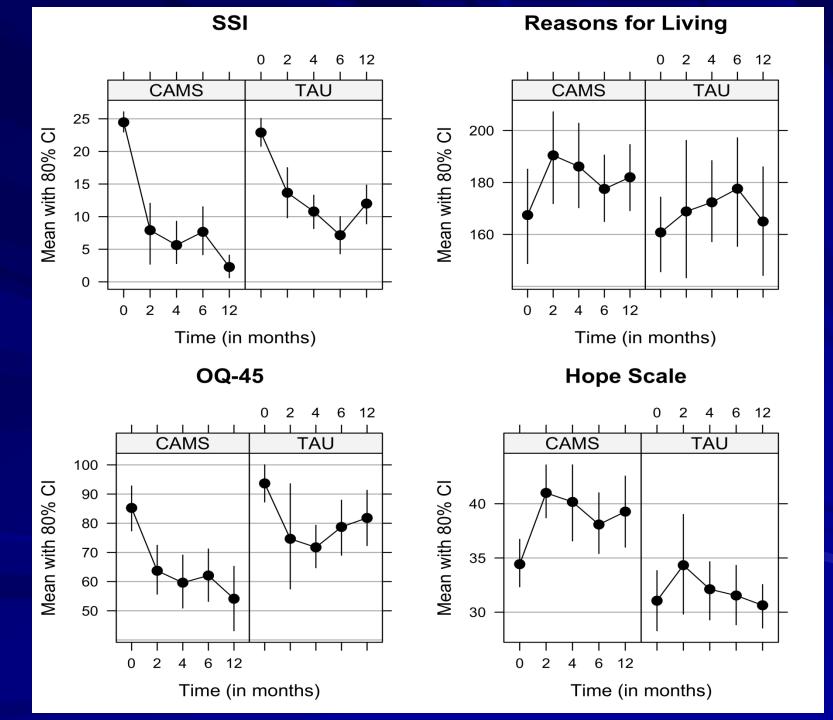
- Component I. Collaborative Assessment of Suicidal Risk
- Component II. Collaborative Treatment Planning
 - → Attend treatment reliably as scheduled over the next three months
 - → Reduce access to lethal means
 - → Develop and use a Coping Card as part of Crisis Response Plan
 - → Create interpersonal supports
- Component III. Collaborative Deconstruction of Suicidogenic Problems
 - → Relationship issues (especially family)
 - → Vocational issues (what do they do?)
 - → Self-related issues (self-worth/self-esteem)
 - → Pain and suffering—general and specific
- Component IV. Collaborative Problem-Focused Interventions
- Component V. Collaborative Development of Reasons for Living
 - → Develop plans, goals, and hope for the future
 - → Develop guiding beliefs

Correlational Support for SSF/CAMS

| Authors | Sample/Setting | n = | Significant Results |
|----------------------|---|-----|--|
| Jobes et al., 1997 | College Students Univ. Counseling Ctr. | 106 | Pre/Post Distress Pre/Post Core SSF |
| Jobes et al., 2005 | Air Force Personnel Outpatient Clinic | 56 | Between Group Suicide Ideation, ED/PC Appts. |
| Arkov et al., 2008 | Danish Outpatients CMH Clinic | 27 | Pre/Post Core SSF Qualitative findings |
| Jobes et al., 2009 | College Students Univ. Counseling Ctr. | 55 | Linear reductions Distress/Ideation |
| Nielsen et al., 2011 | Danish Outpatients CMH Clinic | 42 | Pre/Post Core SSF |
| Ellis et al., 2012 | Psychiatric Inpatients | 20 | Pre/Post Core SSF Ideation, Depression, Hopeless, Suic. Cog. |

Harborview CAMS Feasibility Consort Chart





CAMS RCT at Ft. Stewart, GA

Consenting Suicidal Soldiers (n=150)

Control Group
E-CAU
3 months of
outpatient care (n=75)

Experimental Group
CAMS
3 months of
outpatient care (n=75)

<u>Dependent Variables</u>: Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Primary Care visits, Emergency Department Visits, and Hospitalizations.

Measures: SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)

Some Next Steps for CAMS

- VA E-Learning training of CAMS (Magruder, York, Marshall, & De Santis)
- VAMC use of CAMS-Groups (Johnson, Jobes, & O'Connor)
- CAMS Brief Intervention(Jobes, O'Connor, & Jennings)
- Web-based electronic version of CAMS and SSF (Koerner & Jobes)

